REQUIREMENTS AND LIMITS

APPLICABLE TO SPECIFIC SERVICES -- Supplement 3 to Attachment 3.1-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

CASE MANAGEMENT SERVICES
HIV Infected Individuals

A. Target Group:

see attachment

B. Areas of State in Which Services Will Be Provided:

__X__ Entire State

_____ Only in the following geographic areas (authority of §1915(g)(1) of the Act is invoked to provide services less than statewide):

C. Comparability of Services:

_____ Services are provided in accordance with §1902(a)(10)(B) of the Act.

__X__ Services are not comparable in amount, duration and scope. Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of §1902(a)(10)(B).

D. Definition of Services:

see attachment

E. Qualifications of Providers:

see attachment

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F. The State assures that the provisions of case management services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

H. Reimbursement Methodology:

see attachment

A. Target Group: Persons who are certified for and are receiving Maryland's Medical Assistance benefits and who are diagnosed as HIV (human immundeficiency virus) infected or who are children less than 2 years old born to a woman diagnosed as HIV infected. HIV infection would be determined by the enzyme-linked immunosorbent assay (ELISA) and confirmed by the Western Blot, or another generally accepted diagnostic test for HIV infection. Participation is conditional on the recipient's election of HIV targeted case management and on comparable case management services not being reimbursed under another Program authority.

D. Definition of Services:

1. Case management means services which will assist participants in gaining access to the full range of Medical Assistance services, as well as to any additional needed medical, social, housing, financial, counseling, and other support services.

2. The Maryland Medical Assistance Program covers the following services when they have been documented as appropriate and necessary:

a) HIV diagnostic evaluation services include, as a unit of service, performance of a multidisciplinary assessment or reassessment, development or revision of a recommended plan of care, and performance of all other necessary covered services as described in D.3.:

b) HIV ongoing case management services include, as a unit of service, a monthly telephone call to the participant and all other necessary covered services as described in D.4.

3. "HIV diagnostic evaluation services" means a multidisciplinary assessment or reassessment of a participant and development or revision of an individualized plan of care by a multidisciplinary team convened by an approved HIV diagnostic evaluation services provider. A multidisciplinary team, which includes the participant or the participant's legally authorized representative(s) and the ongoing case manager chosen by the participant, performs the multidisciplinary assessment or reassessment by:

a) Reviewing relevant medical and other records, with the participant's or legal representative's written consent;

b) Consulting with the participant's attending physician and current providers of medical, social, and other support services, as appropriate;

c) Conducting a face-to-face assessment of the participant, preferably at the participant's residence, to determine the participant's general physical and psychological condition, as well as the participant's environmental, social, and functional status and full range of service needs;

d) Consulting, as appropriate, with the participant or the participant's legally authorized representative(s); and

e) Developing a written, individualized plan of care which reflects both the needed and available services being recommended for delivery.

4. On-going case management means the activities involved in participating as a member of the diagnostic evaluation provider's multidisciplinary team for a client and then implementing and monitoring the plan of care, as performed by a case manager through an approved HIV ongoing case management provider agency.

These services shall be provided to participants who select this service and who are recommended by the HIV diagnostic evaluation services provider as needing ongoing case management services. Covered services provided by the case manager include:

a) Acting as a point of contact for the case, to insure a continuum of care;

b) Serving as a member of the HIV diagnostic evaluation services provider's multidisciplinary team when multidisciplinary assessments or reassessments are performed for the case manager's clients by:

1) Conducting a face-to-face assessment of the participant's psychosocial status and health care needs and briefing the multidisciplinary team on the findings,

2) Participating in the development or revision of an individualized plan of care for the participant,

3) Encouraging the participant or legal representative's participation in the multidisciplinary team process, and

4) Linking the participant with any services needed on an emergency basis before the plan of care or revision is finalized;

c) Implementing the plan of care by advising the participant about available services and service providers, by making referrals to and arrangements with service providers selected by the participant, and by assisting the participant in gaining access to services for which the client is eligible and which he/she chooses, to include:

1) the full range of Medical Assistance services and

2) any other available support services such as medical, social, housing, financial, and counseling;

d) Providing the participant with any necessary counseling concerning government entitlement programs, health, social, educational, psychological, financing, housing, and other resources;

e) Coordinating implementation of the plan of care with the participant's family or other persons providing care;

f) Following up promptly after referral to service providers to ensure that the services are being received and are sufficient in quantity and quality to meet the client's needs;

g) Monitoring the services provided and the service delivery to verify that the services were received and to determine whether they are appropriate in quantity and quality. Monitoring shall include, but not be limited to:

1) Monthly telephone contact with the participant and other contacts as necessary with the family, caregivers, and service providers;

2) Home visits with the participant; and

3) Review of relevant records, with the participant's written consent;

h) Coordinating service provision and resolving conflict between service providers or between a service provider and the participant;

i) Participating in crisis assistance planning and counseling between service providers or between a service provider and the participant;

j) Assessing the client and the relevant records as necessary to determine the client's current status and progress and whether any revision is needed in the plan of care or in the provision of services;

k) Referring the client back for reassessment by the HIV diagnostic evaluation services provider at least annually and anytime during the year as determined necessary by the case manager and the participant's chosen HIV diagnostic evaluation services provider when a significant change in the participant's condition or circumstances requires a reassessment or update to the plan of care; and

l) Determining the client's continuing need and desire for ongoing case management services no later than 60 days after the service begins and at least every 6 months thereafter.

5. Reimbursements will not be made for HIV targeted case management services if the participant is receiving comparable case management services under another Program authority.

E. Qualifications of Providers:

1. HIV diagnostic evaluation services providers and HIV ongoing case management providers offer covered case management services to participants through a provider agreement signed with the Department of Health and Mental Hygiene and are identified as Program providers by issuance of an individual account number.

2. General requirements for participation in the Medical Assistance Program are that providers shall:

a) Ensure that employees participating as case managers in targeted case management for HIV-infected individuals meet the licensure requirements for registered nurses, social workers, or physicians in the jurisdiction in which services are rendered;

b) Apply for participation in the Program using an application form designated by the Department;

c) Be approved for participation by the Department;

d) Have a provider agreement in effect with the Department;

e) Be identified as a Program provider by issuance of an individual account number;

f) Verify the licenses and credentials of all professionals who are employed by the provider of services;

g) Verify the eligibility of recipients;

h) Accept payment by the Program as payment in full for services rendered and make no additional charge to any person for the covered HIV targeted case management services;

i) Provide services without discrimination on the basis of race, color, age, sex, national origin, marital status, and physical and mental handicap;

j) Maintain adequate records for a minimum of 6 years and make them available, upon request, to the Department or its designee;

k) Not knowingly employ or contract with a person, partnership, or corporation which has been disqualified from the Program to provide or supply service to Medical Assistance recipients unless prior written approval has been received from the Department;

l) Agree that claims rejected for payment due to late billing may not be billed to the participant;

m) Agree that if the Program denies payment or requests repayment on the basis that an otherwise covered service was not medically necessary, the provider may not seek payment for that service from the participant;

n) Maintain a file on each participant which meets the program's requirements and which includes for each contact made by the case manager:

1) Date and subject of contact,
2) Person contacted,
3) Person making the contact,
4) Nature, extent, and unit or units of service provided, and
5) Place of service;

o) Document, on periodic reporting forms or printouts specified by the Department, the covered services provided to participants; and

p) Not place a restriction on the recipient's right to choose a provider.

3. Specific requirements for participation in the Program as an HIV diagnostic evaluation services provider are that the provider shall:

a) Be a physician or a health or social services entity which employs or has a written agreement with medical professionals (e.g. licensed physicians or registered nurses) or licensed social workers for provision of its diagnostic evaluation services, who are experienced or trained in provision of services to HIV infected individuals;

b) Have a written plan for the implementation of HIV diagnostic evaluation services;

c) Be available to participants at least 8 hours a day, 5 days a week, except on State holidays;

d) Have existing policies and procedures concerning the performance of HIV diagnostic evaluation services;

e) Develop procedures to expedite assessments and reassessments when necessary;

f) Convene a multidisciplinary team for each participant, which performs the multidisciplinary assessment or reassessment and develops or revises an individualized plan of care on a form designated by the Department;

g) Inform the participant or the participant's legally authorized representative(s) of the recommendations for the plan of care in the multidisciplinary assessment or reassessment and of the availability of the needed services;

h) Reassess a participant when the participant's chosen case manager recommends, and the participant's chosen HIV diagnostic evaluation provider agrees, that a significant change in the participant's status necessitates a review or revision of the plan of care;

i) Have a written agreement with any entity approved as an HIV ongoing case management provider which a participant may choose as the provider of ongoing case management. The agreement shall permit the case manager chosen by the participant to participate as a member of the multidisciplinary team, to have access to the plan of care, and to request a reassessment as necessary;

j) Have access to specialty physicians experienced and trained in provision of services to HIV infected individuals, for consultation as necessary concerning a participant's medical assessment and the medical services recommended in the plan of care; and

k) Submit to the Program at the end of every quarter the lesser of the actual number of plans of care completed that quarter for participants or a sample of 10 plans of care.

4. Specific requirements for participation in the program as an HIV ongoing case management provider are that the provider shall:

a) Be a health or social services entity employing registered nurses, licensed social workers, or physicians as HIV case managers, who are experienced and trained in provision of services to HIV infected individuals;

b) Have a written agreement:

1) With any entity approved as an HIV diagnostic evaluation services provider from whom the ongoing case management provider is accepting referrals, and

2) Which permits the case manager to participate as a member of the multidisciplinary team, to have access to the plan of care, and to request a reassessment as necessary;

c) Have a written plan for the implementation of HIV ongoing case management services consistent with Departmental guidelines;

d) Have existing policies and procedures concerning the performance of HIV ongoing case management;

e) Provide ongoing case management services to participants who have been assessed by an HIV diagnostic evaluation service provider, have been recommended for ongoing case management services in the plan of care, and elect to receive ongoing case management services;

f) Be available to participants at least 8 hours a day, 5 days a week except on State holidays;

g) Be knowledgeable of the eligibility requirements and application procedures of applicable federal, state and local government assistance programs;

h) Maintain a current listing of medical, social, housing assistance, mental health, financial assistance, counseling and other support services available to HIV-infected individuals;

i) Have established alternatives for managing participants' medical and social crises during off-hours, that will be specified in participants' individualized plans of care;

j) Have at least one face-to-face contact with the participant during each six month period; and

k) Submit to the Program, when starting to bill for ongoing case management services rendered to a participant, a form designated by the Department, which identifies the completion date of a plan of care consistent with the requirements of this chapter.

5. The case manager must be a registered nurse, licensed social worker, or licensed physician who meets the licensing requirements of the jurisdiction in which services are rendered and who is employed by the HIV ongoing case management provider. The case manager assumes responsibility for the case, participating as a member of the multidisciplinary team convened by the HIV diagnostic evaluation services provider, functioning as the case manager chosen by the participant, acting as a point of contact for the case, and implementing and monitoring the plan of care recommended by the HIV diagnostic evaluation services provider's multidisciplinary team and approved by the participant. The case manager shall be experienced and trained in provision of services to HIV-infected individuals.

EXHIBIT I

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory MARYLAND

CASE MANAGEMENT SERVICES FOR CHRONICALLY MENTALLY ILL ADULTS

A. Target Group:
See Attached

B. Areas of State in which Services Will Be Provided:
_____Entire State
_X_ Only in the following geographic areas (authority of 1915(g)(1) of the Act is invoked to provide services less than statewide):

Baltimore City, Calvert, Montgomery, St. Mary's and Washington Counties

C. Comparability of Services:
_____Services are provided in accordance with 1902(a)(10)(B) of the Act.

_X_ Services are not comparable in amount, duration and scope. Authority of 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of 1902(a)(10)(B).

D. Definition of Services:
See Attached

E. Qualifications of Providers:
See Attached

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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REQUIREMENTS AND LIMITS
EXHIBIT I (Cont.) APPLICABLE TO SPECIFIC SERVICES — EXHIBIT I

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

H. Reimbursement Methodology:

(see attached)

A. Target Group: Persons who are certified for and are receiving Maryland's Medical Assistance benefits (which excludes individuals between the ages of 22 and 64 who are residents of institutions for mental disease) and who:

1. Are residents of Baltimore City, Calvert County, Montgomery County, St. Mary's County, or Washington County;

2. Is at least 18 years old;

3. Elect, or have a legally authorized representative elect in the participant's behalf, to receive Mental Health Case Management;

4. Qualify as part of the Mental Hygiene Administration's priority population, which receives priority for services funded or administered by MHA based on being cchronicallymentally ill, having limited financial resources to obtain required treatment, and meeting all of the following criteria:

(a) Having major mental illness as the primary diagnosis, as defined by at least one of the following:

(1) Schizophrenic disorder (DSM-IV 295.00-295.99),

(2) Major affective disorder (DSM-IV 296.00-296.89),

(3) Organic mental disorder (DSM-IV 290.00-290.99,293.00-294.99, or 310.00-310.99),

(4) Other psychotic disorder (DSM-IV 297.00-298.90), or

(5) Borderline schizoid and schizotypal personality disorders (DSM-IV 301.83 or 301.20-301.22 with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; or

(b) Having impaired role functioning resulting from mental illness, as defined by meeting at least three of the following five criteria on a continuing or intermittent basis for at least 2 years:

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